Hodgkin’s Disease

While tuberculosis is always to be kept in mind in making a diagnosis when a patient presents himself with obscure pulmonary or other suggestive signs and symptoms, nevertheless tuberculosis frequently becomes a dumping ground for numerous vague non-tuberculous conditions which assail mankind, and which on careful study and investigation can be properly diagnosed. One of these conditions, arising on account of early cervical glandular enlargement and either early or late pulmonary manifestations, is Hodgkin’s disease.

This condition was first described by Hodgkin in 1832 and has since been variously designated as lymphogranuloma, psuedo leukemia, lymphosarcoma, malignant lymphoma, splenic anemia, chronic relapsing fever, lymphadenoma and anemia lymphatica. This confusing terminology illustrates the difficulty in arriving at a satisfactory classification of this condition which is considered an infection by some and a neoplasm by others. The histo-pathology in brief however is more suggestive of a neoplastic than of a granulomatous process. The typical form of the disease is characterized by a slowly progressive enlargement of the lymph glands throughout the system, a progressive secondary anemia, fever, and generally a fatal termination within three to five years.

Age and Sex.

Hodgkin’s disease is most common in young adults and relatively rare after the fourth decade of life, but is not at all rare in childhood. Ziegler in reporting 220 cases found 16 and 17 percent respectively in the first two decades of life. The condition is twice as common in adult males as in females. In younger children in the first decade of life the predominance of males is very much greater, being approximately four to one.

Smith of Ann Arbor, in reporting 23 cases in children up to 14 years of age, found only two females, while in six years at the same institution (The University of Michigan) the total number of adult cases reported showed 66 and 34 percent respectively for males and females. These percentages rather tend to nullify the theory held by some that the disease might be related in some way to repeated infections of some sort, as males are supposedly more frequently exposed to infectious agents by occupation. In the younger groups one would hardly expect the environment of one sex to differ greatly from the other. On the other hand it is logical to assume that the matter of sex points rather to the type of etiology for Hodgkin’s disease as well as for leukemia or true lympho-sarcoma. Smith points out that of nineteen children with lymphatic leukemia fifteen were boys, while of eleven children diagnosed as having true lympho-sarcoma only one was a girl.

There are no constant reports in the literature relating Hodgkin’s disease to preceding infections and possible foci of infection. Some observers have thought that conditions in the nasal sinuses, mouth, and throat play some etiologic role because of the common onset in the cervical glands. This however has not been found to be the case by those reporting large series of cases, aside from the fact that it would be difficult to associate Hodgkin’s disease in very young infants with such an etiology. There does however, seem to be a slight familial tendency to the disease, as several cases occurring in the same family are not at all rare, and it is particularly common in the same family in twins.

Relation to tuberculosis.

This relationship has been the subject of considerable study. Sternberg in 1892 thought that Hodgkin’s disease was a...
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glandular form of tuberculosis, but Dorothy Reed and Longscope definitely decided that they are two separate disease entities. Not so long ago L’Esperance claimed he was able to produce avian tuberculosis by inoculating chickens with material extracted from the enlarged glands and has attracted fresh attention to the possibility of such a connection. Ewing states that family history showing tuberculosis or tuberculous lesions in the body is the rule in these patients, Ziegler, however, claims that it occurs in only about 20 percent of the cases. Parker and his associates in a study of pathologic rather than clinical material have found a significantly greater percentage of tuberculosis both healed and active in Hodgkins’ than in other types of lymphoma. This author in the past several years, has observed two cases of Hodgkins’ disease, one co-existing with an advanced pulmonary tuberculosis, and another with a minimal early upper lobe involvement. Both patients had positive sputum and both came to autopsy which confirmed the diagnosis of both conditions.

A rather interesting paradox is the relative infrequency of positive tuberculin reactors in Hodgkins’ disease. Bastai suggests that this might be explained by a tuberculin anergy produced by the disease. He found that following radiation therapy, negative reactors often gave a positive reaction. It may be suggested that it is because of this anergy that tuberculosis is so often found associated with this disease and spreads so rapidly, particularly in view of the fact that many of these cases are wrongly diagnosed as tuberculosis and placed in sanatoria where they are continuously in close contact with the tubercle bacillus.

Symptoms.

The disease is very insidious in its onset and the usual history is the discovery of a painless, slowly enlarging gland. The most common site of enlargement is in the cervical glands and more frequently the glands of the left side are the first to be involved. Feer has offered this explanation: that there is truly a primary involvement of the retroperitoneal and mesenteric lymph glands. By lymphatic extension such processes would first show themselves in the left neck glands, because of the course of the thoracic duct. This seems reasonable as even symptomatically many patients have constipation alternating with diarrhea and abdominal distress even early in the course of the disease. It also indicates the importance of directing radiation treatment to the abdomen as well as the cervical region which appears to be the only seat of involvement. No tissue in the body is exempt and the first involvement may even occur in the bones or central nervous system. Usually other tissues become infiltrated as the disease progresses, but it is found early in its course in the mediastinal, axillary, mesenteric and inguinal glands. The spleen and liver are involved later in the disease and can be readily palpated. Their enlargement is a serious prognostic sign. Cutaneous manifestations frequently occur as a simple urticaria, petechiae, edema, bronzing or other non-specific lesions, or there may be actual dermal infiltration with the Hodgkins tissue.

As the disease progresses there occurs malaise, anemia, cachexia, and fever with certain sequelae resulting from pressure of tumorous glands such as nausea, vomiting, diarrhea and abdominal distress from mesenteric involvement, or respiratory difficulties from encroachment on the bronchi and mediastinum such as to produce symptoms resulting from atelectasis, abscess formation, or pleural effusion. Parasthesias can occur from pressure on the nerves as also delirium and palsies from central nerve involvement. As the disease progresses, fever is usually a constant feature and ranges from 100 to 104 degrees.

The blood picture generally shows nothing characteristic except a progressively increasing anemia, a relative increase in lymphocytes and a relative leukopenia.

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particularly when the temperature is taken into consideration. As the disease progresses towards its terminal stage these patients become bedfast with extreme weakness, progressive edema, and anasarca until death comes from sheer exhaustion.

The average duration of life is reported to be about three years, although there are instances on record of fifteen years duration. There are, on the other hand, definitely acute fulminating cases whose course terminates fatally in from three to eight months regardless of treatment.

In the more common forms, however, the disease is insidious and more slowly progressive with remissions and relapses. Those who have the most prolonged course are those in whom radiation therapy has been started early in the disease.

Treatment.

Everything in the pharmacopea has been used with little or no benefit. Serum and vaccines, transfusions and autohemotherapy have been reported as beneficial by some observers. However, the disease terminates fatally in all patients, and treatment leads to no permanent results. The only treatment that gives symptomatic relief and prolongs life is roentgen therapy. There is no question that under radiation the enlarged glands undergo rapid involution with symptomatic relief and many patients have been well enough under this treatment to pursue their occupations and lead relatively normal lives for a certain length of time.

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